in our legislation is deferring almost entirely to the oversight of medical judgment that has traditionally been regulated by State law.

I point out that the Judicial Conference of the United States has spoken on this issue. The Chief Justice of the United States, Chief Justice Rehnquist, is the presiding officer of the Judicial Conference of the United States.

The Judicial Conference, through its executive committee, adopted the following position on February 10, 2000:

The Judicial Conference urges Congress to provide that in any managed care legislation agreed upon—

This is the legislation we are talking about today—

that State courts be the primary forum for the resolution of personal injury claims arising from the denial of health care benefits.

The Judicial Conference of the United States, a nonpartisan, nonpolitical body headed by the Chief Justice, decided that cases involving medical judgment should go to State court. These types of cases have been traditionally resolved in State court.

Federal courts, of course, are courts of limited jurisdiction. And these are not cases that should go to Federal court. Our bill does exactly what the Judicial Conference, headed by our Chief Justice, has recommended. It sends these cases to the place where they have traditionally been decided.

Contract cases, based solely on what the terms of the contract are—for example, if there were a provision requiring that insurance coverage be in place for 60 days before payment can be made for any particular treatment—if there were a dispute about whether 60 days had actually passed, or whether the coverage or the contract applies, that would be an interpretation of the contract and would go to Federal court. In those limited cases where there is a dispute about the actual language of the contract, those cases go to Federal court.

There are limitations contained in our bill about any recovery in Federal court. The basic structure here is simple: medical judgment cases, where the HMO is inserting its judgment for that of the health care provider, go to State court. Cases that have always traditionally been decided in State court go to State court, just as our Chief Justice in the Judicial Conference is recommending. The only cases that go to Federal court, a court of limited jurisdiction, are cases involving pure interpretation of the contract—cases that have historically been decided in Federal court under ERISA. So they essentially maintain the same bifurcation that the U.S. Supreme Court suggested.

We have included a balanced approach and imposed some limitations. Under our bill, there are no class actions. Appeals have to be exhausted, except for the very rare circumstance where the patient can show an immediate and irreparable harm. In all other cases, internal and external appeals have to be exhausted before a patient can go to court.

Third, the vast majority of cases go to State court and are therefore subject to whatever State court limitations apply. For example, the limitations that exist under State law in Texas would apply to cases that go to State court in Texas.

We are attempting to balance interests and create really meaningful and enforceable rights for the patient, giving the patient the ability to enforce those rights through an appeals process, and then, as a matter of absolute last resort—and as history has proven, it happens very rarely—giving them the right to take the HMO to state court, where these kinds of cases are traditionally decided.

We have debated this issue over and over on the floor of the Senate. Many Members of the Senate have been involved. Congressmen NORWOOD and DINGELL have led the effort on the House side in the debate. It is time for us to get past simply talking about this issue and debating the various parties' positions. Senator MCCAIN and I, along with others in support of this bill, are making an effort to resolve our differences and get this legislation enacted. It is time, finally, that we enact legislation that puts law on the side of the patients, on the side of families, and on the side of doctors, and not on the side of big HMOs and insurance companies.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. VOINOVICH. Madam President, I ask unanimous consent to speak for up to 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

FEBRUARY AS AMERICAN HEART MONTH

Mr. VOINOVICH. Madam President, I rise today to highlight February as American Heart Month, a designation that has stood since 1963 when Congress first recognized the need to focus national attention on cardiac health. I think it is particularly appropriate since it is Valentine's Day.

The theme of this year's Heart Month is one that resonates deeply with me: ''Be Prepared for Cardiac Emergencies.'' This theme is especially meaningful because on January 20, the day of the Presidential Inauguration, the Voinovich family almost lost one of its beloved members to sudden cardiac arrest.

Indeed, as the country welcomed the arrival of a new administration, I, like many of my colleagues, was looking forward to sharing this joyous occasion with family and friends. Tragically, our celebration was suddenly upended when Patricia Voinovich, my brother Vic's wife, was struck by sudden cardiac arrest. As she entered the Ohio Inaugural Ball, she crumpled to the ground without a pulse or respiration.

Sudden cardiac arrest—as the name imples—happens abruptly and without warning. It occurs when the heart's pumping chambers suddenly stop contracting effectively and as a result, the heart cannot pump blood.

Although it has received much less attention than heart attacks, sudden cardiac arrest is a major cause of death in the United States.

This usually fatal event causes brain damage or death within minutes if treatment is not received immediately, and is estimated to cause more than 220,000 deaths in the United States annually.

That is more than three lives every 7 minutes—more than 600 deaths a day. These deaths are largely attributed to the lack of preparedness and immediate accessible medical attention in the short window between the heart ceasing to pump and death.

Just as in most sudden cardiac arrests, with Pat there was no warning or indicating that she would be susceptible to such a sudden physical trauma. She was in good health. As a matter of fact, she had just been to the doctor and had a check up.

Even after the incident, doctors commented that her heart was undamaged and healthy. After she became stabilized, my family and I listened to the doctors at the George Washington University Hospital who informed us just how lucky Pat, Vic, and the rest of the family had been. I was told that when individuals are struck with sudden cardiac arrest, only a minuscule number, 5 percent, survive.

Fortunately, Pat had been blessed to be in a place where there was what the American Heart Association calls a strong chain of survival in place.

As a matter of fact, one of the doctors from George Washington University Hospital had been assigned to the convention center for the specific purpose of responding to an incident such as the one that occurred to my sister-in-law.

It was only 2 or 3 months before the inaugural ball that this equipment had been put in place at the convention center in anticipation that something like this could happen. I think all convention centers throughout the United States should have that equipment on board. I think all of us here in the Senate should feel very fortunate that because of Dr. FRIST, that kind of equipment is available to the floor of the Senate and the House and the corridors of the Capitol.

The chain of survival, developed by the American Heart Association, is a four-step process to saves lives from cardiovascular emergencies. The process includes early access to emergency medical services, early CPR, early defibrillation and early access to advanced cardiovascular care. Its goal is to minimize the time from the onset of symptoms to treatment.

Although I did not know it at the time, all of these factors were present that night at the Ohio Inaugural Ball.

Indeed, the American Heart Association estimates that if what they call a strong chain of survival is in place, the survival rate of sudden cardiac arrest would increase to upward of 20 percent, saving as many as 40,000 lives per year. Think of that—40,000 lives per year if that chain of survival exists.

As pat lay there on the floor following her collapse, I can only thank God that this chain of survival was present and went into effect. Secret Service agents and an on-hand emergency physician came to her side almost immediately.

These Good Samaritans began administering CPR, as well as utilizing a lifesaving machine called an automatic external defibrillator, also known as an AED. If it had not been for the grace of the Holy Spirit, the rapid response of Secret Service agents and the on-hand emergency physician and the presence of an AED, pat almost certainly would not have survived.

The American Heart Association has been a longtime leader in educating the country in cardiovascular disease and the need for preparing for cardiac emergencies.

Unfortunately, many Americans do not realize the kind of education and training that the Heart Association can provide until after an emergency situation occurs. I have certainly become even more aware of their services in light of my family's situation.

Quite simply, being prepared for a cardiac emergency can and does save lives. It is my hope, that by focusing on this year's American Heart Month theme—''Be Prepared for Cardiac Emergencies''—we can save many thousands of lives, not only this year, but in years to come.

I encourage all Americans to participate in American Heart Month, and take the time to educate themselves so that they will be prepared and know what do when an emergency strikes.

For those of you who might be interested in how Pat is doing, she was in the hospital for 5 days. They inserted a defibrillator in her chest, so if she has another occurrence that defibrillator will respond to it.

My brother thanked me profusely for inviting him to the inauguration because he said Pat had this preexisting condition they did not know about, and if it had occurred somewhere else instead of the Convention Center, she would no longer be with us.

So we have a happy ending to what could have been a real tragedy for our family which, again, emphasizes that because of some folks out there who became involved in the chain of survival, she is now alive and well and able to take care of her family.

Thank you, Madam President.

Madam President, I suggest the absence of a quorum.

The legislative clerk proceeded to call the roll.

Mr. DORGAN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DORGAN. Madam President, are we in morning business?

The PRESIDING OFFICER. The time until 12 noon is under the control of the Democratic leader.

RECOGNIZING AMERICAN HEART MONTH

Mr. DORGAN. Madam President, I want to talk about two items today. The first deals with February being American Heart Month. Let me describe my interest in this issue.

Today, of course, is Valentine's Day. Most of us will receive some kind of valentine from someone that has a red heart on it and describes love and affection. It is a wonderful day for all of us.

The other symbol is the human heart, which is a symbol that relates to the American Heart Association, an organization I have worked with a great deal. And also, as I said, this is American Heart Month.

Robert Benchley once said: ''As for me, except for an occasional heart attack, I feel as young as I ever did,'' describing, of course, the devastation of the cardiac problems that people who suffer from heart disease have.

I want to talk, just for a moment, about that because we need to continue every day in every way to deal with this killer in our country. Heart disease is this country's number 1 killer. It is the leading cause of disability and the leading cause of death in our country.

Forty-one percent of the deaths in our country each year are caused by heart disease and other cardiovascular diseases, more than the next six leading causes of death combined. Cardiovascular disease and heart disease kill more women than the next 14 causes of death combined each year. That is 5.5 times more deaths than are caused by breast cancer.

How can we help fight heart disease? All of us work on a wide range of issues. I am very concerned about a wide range of diseases. I have held hearings on breast cancer in North Dakota. I have worked on diabetes especially with respect to Native Americans. But heart disease is a special passion for me. I lost a beautiful young daughter to heart disease some years ago, and I have another daughter who has a heart defect. I spend some amount of time visiting with cardiologists and visiting Children's Hospital talking about the human heart.

We know there is much more to be learned about heart disease. There is breathtaking and exciting research going on at the National Institutes of Health dealing with heart disease. I have been to the NIH and visited the researchers. What is happening there is remarkable. Congress is dramatically increasing the funding for research dealing with a wide range of diseases and inquiry into diseases at the National Institutes of Health. We have gone from $12 billion now to over $20 billion, and we are on a path to go to $24 billion in research at the National Institutes of Health.

I am pleased to have been one of those who stimulated that increase in the investment and research to uncover the mysteries of disease. To find ways to cure diseases and to prevent diseases—heart disease, cancer, so much more—is a remarkable undertaking, an outstanding and important investment for the country. How can we, however, as a Congress provide some focus to this issue of heart disease?

We have a Congressional Heart and Stroke Coalition that we founded in 1996. I am a co-chairman of that in the Senate and Senator FRIST, who is a former heart transplant surgeon, is the other co-chair. We have two co-chairs in the House of Representatives as well. We are active in a wide range of areas dealing with the issue of heart disease.

More than 600 Americans die every single day from cardiac arrest. That is the equivalent of two large jet airline crashes a day. But it is not headlines every day because it happens all the time, day after day, every day.

There is some good news, and that is that cardiac arrest can be reversed in a number of victims if it is treated within minutes by an electric shock. There is now something called an automatic external defibrillator, AED. The AEDs, which we have all seen on television programs where they are applying a shock to someone to restart their heart, used to be very large machines. Now they are portable, the size of a briefcase, easily usable by almost anyone, even myself. I was in Fargo, North Dakota, one day with the Fargo-Moorhead ambulance crew, and the emergency folks use these defibrillators, the portable briefcase size defibrillator. They showed me how to hook it up and how to use it.

Without having any experience at all, someone off the street can just hook up one of these portable defibrillators and use it without mistake or error to save lives. The question is, how can we now make these portable defibrillators easily accessible in public buildings all around the country, and other areas of public access, so they're available to help save lives when someone has a sudden cardiac arrest? That is what we are working on.

We have passed legislation to try to make these available in airplanes. We have passed legislation to try to move them around to make them available in public buildings. We should do much more than that. They are affordable, easy to use, and can save lives. We ought to have these new portable defibrillators as common pieces of safety equipment in public buildings like fire extinguishers are now. It is achievable, and it is something we should do.

We also need to find ways to do more cholesterol screening. That also relates